

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (N1505)	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH BROAD STREET MIDDLETOWN, DE 19709
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from April 13, 2015 through April 22, 2015. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 115. The stage II sample totaled forty one (41).</p> <p>Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; RNAC- Registered Nurse Assesment Coordinator; RD - Registered Dietitian; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; UM - Unit Manager; SW - Social Worker; MD-Medical Doctor; FSD - Food Service Director; Psychotropic (medication)- any medication capable of affecting the mind, emotions and behavior; MDS - Minimum Data Set-standardized assessment forms used in nursing homes; POS - Physician Order Sheet; MAR - Medication Administration Record; mg - milligram (unit of mass); cm - centimeter (unit of length); PU-Pressure ulcer-sore area of skin that develops when the blood supply to it is cut off due to pressure; Stage II (2) pressure ulcer -skin forms an open sore or blister. The area around the sore may be red and irritated.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chanda H. [Signature]</i>	TITLE Administrator	(X6) DATE 5-14-15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure dignity was maintained for seven (R2, R27, R37, R111, R131, R145, and R172) out of 41 stage II sampled residents. Findings include:</p> <p>General observation on 4/14/15 revealed the following:</p> <p>1. 4/14/15 at 2:21 PM - E12 CNA knocked, then immediately opened R131's door, without asking permission to enter, while an interview between surveyor and the resident was in progress. The CNA came in to offer R131 snacks.</p> <p>2a. 4/14/15 at 3:35 PM - E10 RN knocked but failed to request permission to enter R27's room. Upon seeing the surveyor, E10 immediately said, "that's ok I'll come back" and started to close the door.</p> <p>b. 4/14/15 3:45 PM - E11 CNA knocked and opened R27's closed door, without asking permission to enter before entering. Upon seeing the surveyor, E11 CNA immediately started to back out of the room & close the door saying "sorry," and that she would return later.</p> <p>4/14/2015 3:50 PM - Findings were discussed</p>	F 241	<p>1. a. No resident was adversely affected</p> <p>b. All residents have the potential to be affected by the deficient practice.</p> <p>c. Social worker/designee will re-educate staff on residents' rights to privacy including knocking, announcing oneself, and waiting for permission to enter before entering residents' room or bathroom.</p> <p>d. Social services to do 3 random observations and 3 resident interviews (attachment 1) daily to assess compliance with residents' rights to privacy until 100% compliance. Social Services to then do 3 random observations and 3 resident interviews 3 times per week until 100% compliance is reached. Social Services to then do weekly observations and interviews, 3 each, for one month or until 100% compliance is reached. Social Services to observe and interview, 3 each, one month later to ensure problem has been resolved</p>	6/12/15
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F 241	<p>Continued From page 2 and confirmed with E10 in an interview.</p> <p>4/14/2015 3:55 PM - Findings were discussed and confirmed with E11 in an interview.</p> <p>3. On 4/13/2015 at 12:20 PM, during the dining observation for lunch in the Strand dining room R2 was having her meal set up and food out by E2 (DON), when E12 CNA stated, "wait ... let me get her (R2) a "bib" and placed a clothing protector around the resident's neck, without asking her permission. Findings were confirmed with the CNA immediately following this observation. E12 then stated "that's what it is ... a bib, like what they put on babies...", this surveyor discussed dignity as concern with E12, and identified the garment as a "clothing protector".</p> <p>Findings were acknowledged by E12 and confirmed with E2 during an interview on 4/15/15 at 9:00 AM.</p> <p>4. On 4/17/15 at 11:40 AM during a second dining observation at lunchtime in the A.J. Cox dining room E13 CNA was observed placing a clothing protector on R37, without asking permission.</p> <p>The following observations occurred at the same time and place:</p> <p>5. E13 CNA was observed placing a clothing protector on R111, without asking permission.</p> <p>6. E13 CNA was observed placing a clothing protector on R145, without asking permission.</p> <p>7. E13 CNA was observed placing a clothing protector on R172, without asking permission.</p>	F 241	<p>2.</p> <p>a. All residents identified still reside at the facility. No resident was adversely affected.</p> <p>b. All resident have a potential to be affected by the deficient practice</p> <p>c. Education was provided to E12 immediately. Nursing staff education on resident rights with clothing protectors and offering them to residents. A focus review was conducted to identify like residents.</p> <p>d. An audit (attachment 12) will be conducted by ADON/designee daily until 100% compliance is achieved for 3 consecutive reviews, three times a week until compliance is achieved for 3 consecutive reviews, then weekly until 100% compliance is achieved for 3 consecutive reviews, then one month later to verify 100% compliance is maintained.</p>	6/12/15

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F 241	Continued From page 3	F 241			
F 278 SS=D	<p>These findings were reviewed and confirmed with E1, NHA and E2 on 4/22/15 at approximately 2:30 PM</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was</p>	F 278	<p>1.</p> <p>a. R.118 no longer resides in the facility</p> <p>b.. All residents with a fall have the potential to be affected by the deficient practice</p> <p>c.. The facility failed to code a fall with injury on the MDS.RNAC will be educated on reviewing anew diagnosis upon completion of the MDS. A focus audit was conducted on 10 new admissions to ensure accurate diagnosis all coded onto the MDS.</p> <p>d . RNAC to audit (attachment 2) other RNAC's readmission MDS to ensure all new diagnosis are accurately recorded. This will be conducted daily on all readmission's until 100% compliance achieved on 3 consecutive reviews, then weekly until 100% compliance achieved on 3 consecutive reviews, then in one month to ensure 100% compliance maintained.</p>	6/12/15	

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F 278	<p>Continued From page 4</p> <p>determined that for two (R118 and R116) out of 41 sampled residents the facility failed to ensure the accuracy of the MDS. Findings include:</p> <p>1. R118 had a nurses' notes dated 11/18/14 that documented a fall at 3:10 AM and transfer to the emergency room at 10 AM when pain developed. The resident was diagnosed with a broken area to the lower spine.</p> <p>Review of the 5-day Medicare MDS dated 11/19/14 revealed the facility failed to document the fall with injury.</p> <p>An interview on 4/20/15 at 2:41 PM with E4, RNAC confirmed that the fall was not included on the MDS and should have been documented.</p> <p>2. Review of R116's nurses' notes revealed that on 11/23/14 a 2cm by 2cm blister was discovered in the area of the lower spine/tail bone. The facility identified this as a stage II pressure ulcer on their wound assessments.</p> <p>Review of the 5-day MDS dated 11/24/14 lacked documentation of a pressure ulcer.</p> <p>A visit by the wound care consultant on 11/25/14 revealed that R116 has a healed stage II pressure ulcer.</p> <p>Review of the 14-day MDS dated 12/1/14 lacked documentation that the resident had a healed pressure ulcer.</p> <p>An interview on 4/20/2015 at 2:39 PM with E4, RNAC revealed that she was not aware that the resident had a pressure ulcer. She stated that the wound care form from 11/25/14 documented a</p>	F 278	<p>2.</p> <p>a. R116 no longer resides in the facility</p> <p>b. All residents with wounds have the potential to be affected by the deficient practice</p> <p>c. The facility failed to code a wound on the MDS. RNAC will be educated on reviewing the wound report prior to submitting the MDS. A focus audit was conducted on 20 new admissions to ensure any wounds identified are accurately coded onto the MDS.</p> <p>d. RNAC to audit (audit 3) other RNAC's MDS if wound is identified in nursing notes to ensure wound accurately coded on MDS. This will be completed daily until 100% compliance achieved on 3 consecutive reviews, then weekly until 100% compliance achieved on 3 consecutive reviews, then in one month to ensure 100% compliance</p>	6/12/15

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F 278	Continued From page 5 closed area and there was no wound care form initiated on 11/23/14 from the nurse's note that discovered the blister.	F 278		
F 280 SS=D	These findings were reviewed and confirmed with E1, NHA and E2 on 4/22/15 at approximately 2:30 PM 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R18) out of 41 Stage 2 sampled residents, the facility failed to ensure that the care plan was reviewed and revised to	F 280	a. R18 still resides in the facility. R 18's care plan was corrected to reflect thin liquids. b. All residents with changes in liquid consistency has the potential to be affected by this deficient practice. c. RNAC, unit managers, and supervisors were educated on the need to update the care plan for all residents with changes in liquid consistency. A focus review was conducted to assure that all residents who have had changes in liquid consistency had an updated care plan to reflect fluid consistency. d. Unit Managers will audit (attachment 13) care plans for all residents with changes in liquid consistency daily until 100% compliance is reached over three consecutive evaluations. Then three times a week for three evaluations until 100% compliance reached. Then audit once a week for three weeks until 100% compliance. Finally will audit one month later to ensure 100% compliance maintained and then deficient practice is resolved.	6/12/15

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F 280	<p>Continued From page 6</p> <p>address R18's change in consistency of liquids. Findings include:</p> <p>Review of R18's clinical record revealed the following:</p> <p>1/7/15- Speech therapy evaluation and plan of treatment documented a recommendation of nectar thick liquids.</p> <p>1/12/15- A care plan was initiated for potential for aspiration (Inhaling food or fluid into the lungs) related to mechanically altered diet as needed thickened liquids.</p> <p>1/20/15- A speech therapy treatment encounter noted "patient achieved ability to advance to thin liquids".</p> <p>1/21/15- A physician's order was written allowing R18 to consume thin liquids.</p> <p>4/9/15- A quarterly MDS assessment in the nutritional status section documented R18 as having no swallowing disorder and receiving a therapeutic diet</p> <p>During an interview on 4/20/15 at 10:32 AM with E7 LPN it was confirmed that R18 receives thin liquids. E7 explained that R18 "came to us on thickened but he was later reevaluated and it [his dietary status] changed."</p> <p>During an interview on 4/20/15 at 10:37 AM with E4 RNAC, it was confirmed that R18's care plan was not revised when he was changed from thickened liquids to thin liquids but had been updated just then on 4/20/15.</p>	F 280		

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F 311	<p>Continued From page 8</p> <p>Review of the CNA documentation sheets for March and April 2015 documented that the resident was independent in eating for breakfast and lunch and required extensive assistance for dinner.</p> <p>On two lunchtime observations (4/15 and 4/17/2015) R19 received a fork to consume her pureed diet. R19 received some cueing and encouragement but was unable to feed herself. Both days R19 proceeded to place her drinking cup into her food. She (R19) has impaired eyesight and was not directed as to where her food was positioned. No attempts were made to feed the resident at these observations. The resident ate less than 10% on both days.</p> <p>On 4/20/2015 a discharge from therapy note documented the resident was "unwilling to complete self-feeding and therefore goal was discontinued at Min A" (minimal assistance) by therapy.</p> <p>An interview with the dietician, E5 on 4/22/2015 at 10:45 AM, revealed the dining room [the Marquis] is designated for residents that are independent and just need cueing. The residents are expected to feed themselves.</p> <p>A third lunchtime observation on 4/22/2015 at 11:30 AM revealed the resident (R19) was again not taking the initiative to feed herself. Staff did not identify her food for her or where it was located. An activities aide, E14 who is certified in food assistance began to feed R19 once everyone else was finished being served.</p> <p>An interview on 4/22/15 around 1: PM with E14 revealed that R19 can feed herself when she</p>	F 311			

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F 311	Continued From page 9 wants to. She further revealed that the resident needs to be fed about every other day. This is inconsistent with the daily documentation by the CNA staff.	F 311			
F 312 SS=D	<p>These findings were reviewed with E1, NHA and E2, DON on 4/22/15 at 2:30 PM</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined that for one (R19) resident out of 41 sampled residents, the facility failed to provide nail hygiene. Findings include:</p> <p>MDS quarterly review on 2/08/2015 documented in Personal Hygiene that R19 required extensive assistance with one person assist.</p> <p>R19 sustained a broken right arm on 3/25/2015 after falling and has limited use of the right arm and hand.</p> <p>Based on three observations (4/13 at 11:30 AM; 4/17 at 11:20 AM; and 4/22/2015 at 11:30 AM) it was determined that R19 had not received grooming of her fingernails, which were excessively long and unclean.</p>	F 312	<p>a. R19 still resides at the facility and had her nails groomed on 4/22/15</p> <p>b. All residents who required assistance with personal hygiene have the potential to be affected by the deficient practice</p> <p>c. House wide focus inspection of all residents' nails was performed and nail hygiene was provided for those who needed it. Education provided to nursing staff on nail hygiene to be completed with showers and prn.</p> <p>d. Unit manager/designee will complete nail hygiene audit (attachment 5) daily on all residents until 100% compliance is achieved on 3 consecutive evaluations, then three times a week until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, then one more time a month later to ensure 100% compliance is maintained.</p>	6/12/15	

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F 312	Continued From page 10 These findings were reviewed with E1, NHA and E2, DON on 4/22/15 at 2:30 PM.	F 312		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334	a. R27 still resides in the facility. Resident was not adversely affected. b. All residents have the potential to be affected by the deficient practice c. The root cause was determined to be that R27 was sent out to the hospital and returned later after flu clinic was completed. Nursing staff educated that upon admit/readmit immunization records will be reviewed and administered to those whose request/are eligible to receive immunization. d. Unit manager/designee will conduct an immunization audit (attachment 6) on all admission/readmission to verify review of immunization records. This audit will be conducted daily until 100% compliance is achieved on 3 consecutive evaluations, then three times a week until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, then one more time a month later to ensure 100% compliance is maintained.	6/12/15

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F 334	<p>Continued From page 11</p> <p>immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interviews and review of other facility documentation, the facility failed to ensure the flu vaccine was administered after receiving the consent for one (R27) out of six sampled residents. Findings include:</p> <p>The facility's policy on flu vaccine administration</p>	F 334		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0850501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH BROAD STREET MIDDLETOWN, DE 19709		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	Continued From page 12 indicates "... It is the responsibility of the licensed nurse to obtain orders from the physicians for each resident to be immunized...". 9/16/14-R27 signed form that consented to receive the flu vaccination. Review of the clinical record lacked evidence that R27 received her flu vaccine in Sept 2014. During an interview on 4/15/15 at 1:42 PM with E2 DON it was confirmed that the facility had no evidence that R27 received the flu vaccine that was consented to and was ordered. These findings were reviewed and confirmed with E1, NHA and E2 on 4/22/15 at approximately 2:30 PM.	F 334			
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of food borne illness. Findings include:	F 371	1. a. No residents were adversely affected. b. All residents have the potential to be affected by this deficient practice. c. The root cause of the deficient practice was that the ice machine was not properly assessed for cleanliness and maintenance needs. In-servicing on ice machine and cleaning and maintenance will be provided to Food Service Director, dietary staff, and facility maintenance staff by the Administrator/designee. All ice machines are professionally serviced bi-annually by an outside contractor and will be inspected monthly by the facilities Maintenance Director/designee. Continued next page-	6/12/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH BROAD STREET MIDDLETOWN, DE 19709	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 13.</p> <p>1. A kitchen tour was completed on 4/20/15 from 9:45 AM to 11:30 AM by a Public Health Inspector. Findings include:</p> <p>The ice machine gasket was noted to be in disrepair and required professional service and emptying to clean and sanitize the machine. There was visible build up of dust, debris and mold found inside the lid and on the inner dispenser of the machine.</p> <p>2. On 4/13/2015 at 11:45 AM lunch was served in the Marquis dining room. It was observed that seven of the seven sandwiches were touched with contaminated gloves by E4 and E16, both activity aides who were manning the dining room. They did not change their gloves after serving, touched unclean items, then returned to the serving table and cut the sandwiches. E4 also served dessert, a pre-cut cake by sticking a fork in it, and then removing it from the fork to a plate each time with a contaminated gloved hand.</p> <p>3. On 4/17/2015 at 11:30 AM E16, uncovered and touched the utensil with her bare hands and proceeded to distribute the flatware with bare hands, touching the eating side of the forks and spoons and the rims of the drinking cups. E17, activity aide, distributed the sandwiches on this day and also touched each one to cut off the crusts with her contaminated gloves.</p> <p>4. On 4/22/2015 at 11:45 AM, E4 and E16 uncovered the wrapped sandwiches and cut the crusts off with contaminated gloves, having touched non-food items while serving.</p> <p>These findings were reviewed and confirmed with</p>	F 371	<p>Continued-</p> <p>d. An audit (attachment 7) will be completed by the dietary supervisor/designee on ice machine cleanliness and good repair. This audit will be daily until 100% compliance is achieved on 3 consecutive evaluations, then three times a week until 100% compliance is achieved on 9 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, then one more time a month later to ensure 100% compliance is maintained.</p> <p>2.</p> <p>a. No residents were adversely affected</p> <p>b. All residents have the potential to be affected by the deficient practice.</p> <p>c. Activity staff educated on appropriate glove use, handling of utensils, handling of food, and cups during meal times. An initial focused audit was conducted throughout facility. No other issues identified.</p> <p>d. Activity Director/designee will audit (attachment 8) meal times to ensure proper infection control is maintained. This audit will be daily until 100% compliance is achieved on 3 consecutive evaluations, then three times a week until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, then one more time a month later to ensure 100% compliance</p>	6/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015	
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH BROAD STREET MIDDLETOWN, DE 19709		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 371 F 441 SS=D	Continued From page 14 E1, NHA and E2, DON on 4/22/15 at approximately 2:30 PM. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 371 F 441	a. R98 and R27 still reside in the facility b. All residents who receive blood glucose monitoring have the potential to be affected by the deficient practice c. A Facility wide audit was completed of all nursing medication carts and correct cleaning wipes were present on each cart. Nursing staff educated on proper type of wipes to cleanse glucometer before and after use. A focused audit was conducted and no other issues identified. d. Unit manager/designee will conduct an audit (attachment 9) to verify correct wipe is present in the nursing cart and nurse on cart is demonstrating appropriate use. This audit will be daily until 100% compliance is achieved on 3 consecutive evaluations, then three times a week until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, then one more time a month later to ensure 100% compliance is maintained.	6/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0850501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH BROAD STREET MIDDLETOWN, DE 19709	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15 infection. This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of facility documentation, the facility failed to ensure that a shared glucometer was cleaned as per the facility policy which posed a potential for infection between residents. Findings include: During the medication pass observation on 4/13/15 12:04 PM E9 LPN did an accucheck (took a blood sample from a resident's finger to check their blood sugar level) on R98 and replaced the accucheck monitor in the medication cart drawer after using it. E9 did not clean the monitor. Then E9 went to do an accucheck on R27. E9 cleaned off the accucheck monitor using an alcohol wipe, then continued to prepare medications. E9 was stopped upon entering another resident's room and asked what was the facility's policy on cleaning the glucometer between residents. She stated she used an alcohol wipe. When asked what she usually uses, she stated "another type of wipe in a package but I don't have any on my cart." When it was discussed that the glucometer needed to be properly cleaned between residents, E9 went to get the proper wipes, returning with MicroKill One alcohol germicidal wipe and cleaned the accucheck glucometer. When asked if this is what she usually uses E9 stated "No, other square wipes... but this is all that was in the storage closet." Findings were discussed and confirmed with E9 LPN on 4/13/15 at 12:06 PM and with E1 NHA on.	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION BROADMEADOW	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH BROAD STREET MIDDLETOWN, DE 19709
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F 441	Continued From page 16 4/13/15 at 4:05 PM. The facility failed to clean reusable equipment, glucometer, after using it with R98 and before using it with R27 according to the facility policy.	F 441		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate clinical records for two (R104 and R154) out of 41 stage II sampled residents. Findings include:</p> <p>1. R104 receives psychoactive medications. Review of R104's clinical record revealed three completed Behavioral/Intervention Monthly Flow Records, none of which were dated. On 4/21/15 at 10:00 AM E2 (DON) stated that the Behavioral/Intervention Monthly Flow Records usually have the month and year typed in the "Date" box and verified that R104's records were not dated. In collaboration with E2, the records</p>	F 514	<p>1.</p> <p>a. R104 still resides at the facility. The dates were added immediately to the Behavior/Intervention Monthly Flow Sheets.</p> <p>b. All residents who receive psychoactive medications that are monitored with behavior/intervention monthly flow records have the potential to be affected by this deficient practice.</p> <p>c. The facility failed to ensure that flow sheets for one resident did not have documented month/year on the forms. A Focus audit was conducted to ensure all Behavior/Intervention Monthly Flow Sheets had a month and year documented. Nursing staff educated to add date when initiating new Behavior/Intervention Monthly Flow Sheets</p> <p>d. Unit manager/designee will conduct a weekly audit (attachment 10) to verify dates are noted on the Behavior/Intervention Monthly Flow Sheets until 100% compliance is achieved on 3 consecutive evaluations, then monthly until 100% compliance is achieved on</p>	6/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0E5060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER CADA REHABILITATION BROADMEADOW			STREET ADDRESS, CITY, STATE, ZIP CODE 800 SOUTH BROAD STREET MIDDLETOWN, DE 19709	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 17</p> <p>were identified as December (2014), January (2015), March (2015) and that February (2015) was missing.</p> <p>2. R154's physician orders from 7/7/14 included a medication for anxiety [generalized term for nervous disorders], Klonopin 0.5mg, give 1/2 tablet orally every day. This order was recorded in the computer in July, 2014 as 1/2 tab = 0.5mg, twice the ordered dose.</p> <p>During an interview with E9 (LPN) on 4/21/15 at 12:15 PM verified the correct dose was dispensed by the pharmacy. E8 (RN) changed the wording in the computer to indicate 1/2 tab = 0.25mg.</p> <p>These findings were reviewed and confirmed with E1 (NHA) and E2 on 4/22/15 at approximately 2:30 PM.</p>	F 514	<p>2.</p> <p>a. R154 still resides at the facility. The dosage was corrected immediately within Matrix.</p> <p>b. All residents have the potential to be affected by this deficient practice.</p> <p>c. This facility failed to review the written MD order when obtained. A Facility wide audit was conducted to ensure all medication orders were entered correctly. Nursing staff educated on proper medication order entry and reviewing written medication order.</p> <p>d. Unit manager/designee will conduct an audit (attachment 11) to verify orders entered correctly in computer system. This audit will be daily until 100% compliance is achieved on 3 consecutive evaluations, then three times a week until 100% compliance is achieved on 3 consecutive evaluations, then weekly until 100% compliance is achieved on 3 consecutive evaluations, then one more time a month later to ensure 100% compliance is maintained.</p>	6/12/15



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 303
Wilmington, Delaware 19806
(302) 577-8661

STATE SURVEY REPORT

NAME OF FACILITY: Cadla Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: April 22, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from April 13, 2015 through April 22, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 115. The stage 2 survey sample totaled forty-one (41)</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced</p>	<p>Cross Refer F-241, F-278, F-280, F-311, F-312, F-334, F-371, F-441, and F-514</p>	<p>6/12/15</p>

Provider's Signature *Clark / K...* Title Administrator Date 5-14-15



DELAWARE HEALTH AND SOCIAL SERVICES

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Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: Cadla Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: April 22, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>by: Cross Refer Cross refer to the CMS 2567-L survey completed April 22, 2015 F241, F278, F280, F311, F312, F334, F371, F441, and F514.</p>		

Provider's Signature _____ Title _____ Date _____



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NAME OF FACILITY: Cadia Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: April 22, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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Provider's Signature _____ Title _____ Date _____